

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4267

CERTIFICATE OF DEATH

04257
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Alton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle COLE Last ARMSWORTHY		4. DATE OF DEATH Month April Day 26 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1934
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Retired		10b. KIND OF BUSINESS OR INDUSTRY State Roads	
11. BIRTHPLACE (State or foreign country) St. Mary's County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James H. Armsworthy		14. MOTHER'S MAIDEN NAME Catherine Cullison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-12-1880	
17. INFORMANT Mrs. Emma T. Armsworthy - Bel Alton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Acute Myocardial Infarction (c) Arteriosclerotic Hypertensive Heart Disease - years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity		INTERVAL BETWEEN ONSET AND DEATH 30 min. 22 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no accident	
20c. TIME OF INJURY Month, Day, Year Hour 5:00 P. M. 4-25-59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Faulkner, Charles, Md		20f. (City or town) (County) (State) La Plata, Maryland	
21. I certify that I attended the deceased from 4-24 , 19 58 to 4-26 , 19 59 , that I last saw the deceased alive on 4-26 , 19 59 , and that death occurred at 2:45 P. M., from the causes and on the date stated above. ACTUAL SIGNATURE V.B. Dettor M.D. ADDRESS (Street, city or town, state) DATE SIGNED La Plata, Maryland April 27, 1959			
PHYSICIAN'S NAME (Type) V.B. Dettor		M.D. La Plata, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/1959	
22c. NAME OF CEMETERY OR CREMATORY St. Ignatius Church Cem.		22d. LOCATION (City, town, or county) (State) Bel Alton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC. * LA PLATA, MD.		24a. REC'D BY REGISTRAR DATE MAY 5 '59	
24b. REGISTRAR'S SIGNATURE Cutting & House			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4268

CERTIFICATE OF DEATH

04258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN TB 1 day.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ATKINSON, Mary Catherine		4. DATE OF DEATH Month April Day 29 Year 1959	
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Jan 57
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months 2 Days 29 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never worked		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Richard S. ATKINSON		14. MOTHER'S MAIDEN NAME Mariatta Freeman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Richard S. ATKINSON.		Address Indian Head.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory collapse. 493X DUE TO (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
INTERVAL BETWEEN ONSET AND DEATH 12 hrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 28 April, 1959 , to 29 April, 1959 , that I last saw the deceased alive on 29 April, 1959 , and that death occurred at 1:55 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. Woody		ADDRESS (Street, city or town, state) La Plata, Md.	
PHYSICIAN'S NAME (Type) ARTHUR C. WOODY		DATE SIGNED 29 April 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/2/59	
22c. NAME OF CEMETERY OR CREMATORY Bates Methodist		22d. LOCATION (City, town, or county) (State) Snow Hill Md	
23. FUNERAL DIRECTOR'S SIGNATURE Richard S. La Plata		24a. REC'D BY REGISTRAR DATE MAY 5 '59	
24b. REGISTRAR'S SIGNATURE Richard S. Kraus			

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04259

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Waldorf</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicians Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES E</u> First Middle Last		DATE OF DEATH <u>4</u> Month <u>30</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-91</u> 9. AGE (In years for birthday) <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bread Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Beaver</u>		14. MOTHER'S MAIDEN NAME <u>Amelia McCavick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>343-09-6983</u>	
17. INFORMANT <u>Elizabeth Beaver, Waldorf, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>4-30-59</u> (c), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>4-30-59</u> Hour o. m. p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. EDELLEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELLEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>5-3-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West End Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wytheville, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 5 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
MASSACHUSETTS

DEPARTMENT OF
HEALTH

CERTIFICATE OF
DEATH

FILE NO.

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REMARKS

SIGNATURE

DATE

TIME

PLACE

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REMARKS

SIGNATURE

DATE

TIME

PLACE

FILE NO.

DATE OF DEATH

TIME OF DEATH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryantown</i> c. LENGTH OF STAY IN 1b <i>4 mos</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryantown</i> d. STREET ADDRESS <i>1</i> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>LUCY AUGUSTA FARMER</i> First Middle Last DATE OF DEATH <i>4 29 1959</i> Month Day Year		5. SEX <i>F</i> 6. COLOR OR RACE <i>C</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>Nov 4 1876</i> 9. AGE (In years (month birthday) yrs. <i>82</i> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Widow</i> 11. BIRTHPLACE (State or foreign country) <i>Md St Marys Co</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>GEORGE HAWKINS</i> 14. MOTHER'S MAIDEN NAME <i>MARY JANE BUTLER</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> 16. SOCIAL SECURITY NO. <i>NO</i> 17. INFORMANT <i>DOROTHY HAWKINS</i> Address <i>Bryantown</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sudden Rt Heart Failure</i> 782.4 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>4-29-59</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>4 29 1959</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>F. J. Edeleu</i> EXAMINER'S NAME (Type) <i>F. J. EDELEU M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>4-29-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/2/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i>		22d. LOCATION (City, town, or county) <i>Bryantown, Md.</i> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Huntt Funeral Home, Haldor, Md.</i> ADDRESS _____		24a. REC'D BY REGISTRAR _____ 24b. REGISTRAR'S SIGNATURE _____ DATE <i>MAY 5 '59</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, mostly illegible text and markings on the form, including what appears to be a large handwritten '2' in the center.]

DEPARTMENT OF HEALTH

[Faint vertical text on the right margin, likely bleed-through from the reverse side.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4271

CERTIFICATE OF DEATH

04261

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write full name and give nearest town) <u>Seatonsville</u>		c. CITY OR TOWN (If outside corporate limits, write full name and give nearest town) <u>Dentalville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>RURAL.</u>	
3. NAME OF DECEASED (Type or print) <u>GOLDING Betty ANNE</u>		4. DATE OF DEATH Month <u>4</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-8-59</u>
9. AGE (In years last birthday) yrs. <u>10</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm Savoy</u>		14. MOTHER'S MAIDEN NAME <u>MARY Louise Golding</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mary L. Golding</u>		Address <u>Dentalville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Atletionis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4-18-59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-9-59</u> to <u>4-18-59</u> , that I last saw the deceased alive on <u>4-10-59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>4-18-59</u>	
ACTUAL SIGNATURE <u>E. J. Green</u> M.D.		DATE SIGNED <u>4-18-59</u>	
PHYSICIAN'S NAME (Type) <u>LABLATA Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>	22d. LOCATION (City, town, or county) (State) <u>Bayswater Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert M. Zupala Md.</u>		ADDRESS <u>APR 24 '59</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2066323XV2

4

CERTIFICATE OF DEATH

04262

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b <i>12 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>John Lewis HEARD</i>		4. DATE OF DEATH Month <i>4</i> Day <i>15</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 10 1877</i>
9. AGE (In years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Michael Heard</i>	
14. MOTHER'S MAIDEN NAME <i>UNK</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>	
16. SOCIAL SECURITY NO. <i>6</i>		17. INFORMANT <i>Helen Heard, La Plata, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gen. Visceral Failure</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Gen. Ant. Arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Chronic</i> <i>Chronic</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>4-15-59</i> <i>plainly</i> that I last saw the deceased alive on <i>4-15-59</i> , and that death occurred at <i>La Plata, Md.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. J. Edelen</i>		DATE SIGNED <i>4-15-59</i>	
PHYSICIAN'S NAME (Type) <i>E. J. EDELEN MD</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-18-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Catherine</i>	22d. LOCATION (City, town, or county) (State) <i>McConchie, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Wb Hof, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 22 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4273 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marbury c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marbury d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RICHARD Middle GEORGE Last MADDOX				4. DATE OF DEATH Month April Day 19 Year 19 59			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH August 29, 1958			
9. AGE (In years last birthday) 8 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY —			
11. BIRTH PLACE (State or foreign country) Charles Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Richard C. Ashto				14. MOTHER'S MAIDEN NAME Louise E. Maddox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Louise E. Maddox - Marbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia. 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE Paul F. Guerin		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/20/59			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/21/59		22c. NAME OF CEMETERY OR CREMATORY Smith's Chapel			
22d. LOCATION (City, town, or county) Bethesda, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Aschert F.H., Inc. - Lab Plata, Md.					
24a. REC'D BY REGISTRAR DATE APR 24 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas					

4000194X45

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4274

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LA PLATA</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LA PLATA</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial Hospital</i>		d. STREET ADDRESS <i>(RURAL)</i>	
3. NAME OF DECEASED (Type or print) First <i>THOMAS</i> Middle <i>W.</i> Last <i>MADDOX</i>		4. DATE OF DEATH Month <i>APRIL</i> Day <i>5</i> Year <i>1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 24, 1895</i>
9. AGE (In years last birthday) <i>63</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov. Powder Worker</i>	
11. BIRTHPLACE (State or foreign country) <i>Chas. Co. MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>JAMES Frederick MADDOX</i>		14. MOTHER'S MAIDEN NAME <i>JANE EMMA LINE LYON</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>	
17. INFORMANT Address <i>Mrs. Lillian V. Posey - Washington, DC</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Failure</i> DUE TO <i>Multiple myocardial infarctions</i> (b) <i>Arteriosclerotic Heart Disease</i> DUE TO <i>420.0</i> (c) <i>14 da.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4 years</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No accident</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>No injury</i> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>La Plata, Charles, Md.</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-23</i> , 19 <i>59</i> , to <i>4-5</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>4-3</i> , 19 <i>59</i> , and that death occurred at <i>8:20 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>V. B. Detton</i>		DATE SIGNED <i>4/7/59</i>	
PHYSICIAN'S NAME (Type) <i>V. B. DETTOR</i>		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>4/8/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Rest</i>		22d. LOCATION (City, town, or county) (State) <i>LA PLATA, MARYLAND</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chert Funeral Home, Inc. - La Plata Md.</i>		24a. REC'D BY REGISTRAR <i>APR 10 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hana</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4275 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7, 11 & 14, Film G241, 4/17/59 fcy

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CHARLES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA c. LENGTH OF STAY in 1b DOA		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Queens c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jamaica 69X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PHYSICIAN'S MEMORIAL HOSP.		d. STREET ADDRESS 189-07 Jamaica Ave. 20x20 120th Street	
3. NAME OF DECEASED (Type or print) THOMAS E MASON		4. DATE OF DEATH Month APRIL Day 3 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-1938
9. AGE (in years last birthday) 20 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY		10b. KIND OF BUSINESS OR INDUSTRY MILITARY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN J. MASON		14. MOTHER'S MAIDEN NAME Anne ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Internal Injuries of Chest DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 30 min. 39 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident - U.S. #301	
20c. TIME OF INJURY Hour 6:50 Month 4 Day 3 Year 59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Newburg, Charles, Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE V. B. DETTOR		DATE SIGNED 4-3-1959	
EXAMINER'S NAME (Type) V. B. DETTOR		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment, 4-7-59	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Long Island National	22d. LOCATION (City, town, or county) (State) Farmingdale New York
23. FUNERAL DIRECTOR'S SIGNATURE Adams ADDRESS Adams Funeral Home, 4748 Wisc. Ave., NW, Wash. DC		24a. REC'D BY REGISTRAR APR 8 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hane	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04266

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

Charles

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Charles

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

La Plata

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

La Plata

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Physicians Memorial Hospital

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

First

Theresa

Middle

Olivia

Last

McDonagh

4. DATE OF DEATH

Month

April 29,

Day

Year

19 59

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

August 20, 1895

9. AGE (In years last birthday)

63 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

self

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Philip Reed Wills

14. MOTHER'S MAIDEN NAME

Mary Louise Bowling

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

no

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

T. P. McDonagh, La Plata, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Multiple fractures skull, right parietal bone, anterior fassa, right orbit.

INTERVAL BETWEEN ONSET AND DEATH
3 1/2 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Laceration brain, 3 1/2 hrs.

(c)

Multiple abrasions of arms and legs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

none

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Vehicular collision. in northbound lane of Rt. 301 and junction of state rt. #225 Subject thrown from car at impact striking road surface with head.

20c. TIME OF INJURY Month, Day, Year

1:45 p. m. EDT 4/29 1959

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Highway

20f. (City or town)

La Plata

(County)

Charles

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

John H. Griffin

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

4-30-59

EXAMINER'S NAME (Type)

John H. Griffin, M.D.

Acting

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

5/2/1959

22c. NAME OF CEMETERY OR CREMATORY

St. Ignatius Cemetery

22d. LOCATION (City, town, or county)

Chapel Point, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

AREHART FUNERAL HOME, INC., *LA PLATA, MD.

ADDRESS

24a. REC'D BY REGISTRAR

MAY 5 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Charles

Charles

La Plata

La Plata

Washington General Hospital

Theresa

Helen

Olivia

April 24

White

August 20, 1935

63

Livingston

Maryland

USA

70014 Road Villa

Henry Louis Swearing

20

20

711, Monmouth, La Plata, Md.

Infected throat on shell, right caudal bone,
anterior lobe, right orbit,
lacrimation duct, 3 mm.

Multiple abscesses of nose and face

nose

In 200 (1) and face of 14, 201 and insertion of
subject's throat from 200 as shown in drawing and in drawing

1:15 - 1:30 P.M. - 1:45 P.M. - 1:55 P.M.

La Plata

Charles

X

X

X

X

Asst.

John H. O'Brien, M.D.

Asst.

John

John

John

John

John

John

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be completed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4277

CERTIFICATE OF DEATH

04267

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LAPLATA</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Nantemoys</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>EN Route - Phys. Mem. Hosp.</i>		1 d. STREET ADDRESS <i>1</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>(BABY GIRL) "A." Posey</i>		4. DATE OF DEATH Month Day Year <i>APR 10 1959</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-10-59</i>
9. AGE (In years lost birthday) yrs. <i>1</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>INFANT</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Archie Posey</i>		14. MOTHER'S MAIDEN NAME <i>MASSIE GAINOR</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Archie Posey</i>		Address <i>Nantemoys, MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity - D.O.A.</i> DUE TO (b) <i>776X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>776X</i> DUE TO (c) <i>776X</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 10, 1959</i> , to <i>April 10, 1959</i> , that I last saw the deceased alive on <i>April 10, 1959</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank G. Susan</i> M.D.		ADDRESS (Street, city or town, state) <i>INDIAN HEAD MD</i>	
DATE SIGNED <i>APR 10 1959</i>			
PHYSICIAN'S NAME (Type) <i>FRANK A. SUSAN MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>4/10/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>MT Hope</i>		22d. LOCATION (City, town, or county) (State) <i>WELCOME MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archer + Funeral Home Inc. LAPLATA MD</i>		ADDRESS <i>Archer + Funeral Home</i>	
24a. REC'D BY REGISTRAR <i>Archer + Funeral Home</i>		24b. REGISTRAR'S SIGNATURE <i>Archer + Funeral Home</i>	
DATE <i>APR 15 '59</i>			

4100 369XVI

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>John Doe, Baltimore, Md.</i>		5. OCCUPATION <i>Teacher</i>		6. MARITAL STATUS <i>Married</i>	
7. DATE OF DEATH <i>Jan 15, 1950</i>		8. TIME OF DEATH <i>10:30 AM</i>		9. PLACE OF DEATH <i>Home</i>	
10. CAUSE OF DEATH <i>Myocardial Infarction</i>		11. DISEASE OR INJURY <i>Coronary Artery Disease</i>		12. MANNER OF DEATH <i>Natural</i>	
13. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. SIGNATURE OF REGISTRAR <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		18. SIGNATURE OF OTHER PARTY <i>John Doe</i>	

4278

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X NANSEMOY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PHYSICIANS MEM. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>(BABY BOY) "B" POSEY</u>				4. DATE OF DEATH Month Day Year <u>APRIL 11 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR. 10, 1959</u>	
9. AGE (In years last birthday) yrs. <u>6</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>6</u>		IF UNDER 24 HRS. <u>6</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE - INFANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>ARCHIE POSEY</u>				14. MOTHER'S MAIDEN NAME <u>MASSIE GAINOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Archie Posey, Nanjemoy</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 10, 1959</u> , to <u>April 11, 1959</u> , that I last saw the deceased alive on <u>April 11, 1959</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank G. Susan</u> M.D. <u>INDIAN HEAD</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>FRANK A. SUSAN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Hope</u>		22d. LOCATION (City, town, or county) (State) <u>WELCOME, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>AREHART FUNERAL Home, Inc, LAPLATA, MD</u>				24a. REC'D BY REGISTRAR DATE <u>APR 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. King</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4200369XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04269

Reg. Dist. No.

4279

Item 7 Film 241 4-27-59 et

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARION Middle LORETTA Last RUSSELL		4. DATE OF DEATH Month April Day 18 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Divorced	8. DATE OF BIRTH Feb. 19, 1927
9. AGE (In years last birthday) 30 3/4		IF UNDER 1 YEAR Months 3 Days 3	IF UNDER 24 HRS. Hours 3 Min. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Mass.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John D. Keith		14. MOTHER'S MAIDEN NAME Arline Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 134-14-5549	
17. INFORMANT Mrs. Arline Keith		635 - Address Brooklyn Ave. Brooklyn, N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning. 890.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Extensive Burns. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration.	
20c. TIME OF INJURY Month, Day, Year Hour xx p. m. 4/18 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Waldorf Charles Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Paul F. Guerin, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		DATE SIGNED 4/20/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/1959	
22c. NAME OF CEMETERY OR CREMATORY Mt. Rest Cemetery		22d. LOCATION (City, town, or county) (State) La Plata, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC. * LA PLATA, MD.		24a. REC'D BY REGISTRAR APR 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Brown			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Registrar. For Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

04270

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> <i>Brayantown Md</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brayantown Charles co md</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>JOSEPH</i> Middle <i>DARBY</i> Last <i>SEMBLEY</i>				4. DATE OF DEATH Month <i>4</i> Day <i>8</i> Year <i>1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/28/85</i>	9. AGE (In years last birthday) <i>74</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Portia Ware 121 Quincy Place N.E. Wash D.C.</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY OCCLUSION</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Gen. Art Sclerosis</i> DUE TO (c) <i>CHRONIC</i>							INTERVAL BETWEEN ONSET AND DEATH <i>4-8-59</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <i>1957</i> 19 <i>4-8-59</i> to <i>4-8-59</i> that I last saw the deceased alive on <i>4-3-59</i> 19 <i>59</i> , and that death occurred at <i>2 P</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>E. J. Edehlen</i> M.D.				ADDRESS (Street, city or town, state) <i>LA PLATA MD</i>			
DATE SIGNED <i>4-8-59</i>							
PHYSICIAN'S NAME (Type) <i>E. J. EDELEN M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/11/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Mary cem</i>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>George G. Nelson</i>				ADDRESS <i>Aguasco md</i>		24. REC'D BY REGISTRAR DATE <i>APR 13 59</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

04271

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN lb 18X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) Physician Memorial		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LEVIN First JOHNSON Middle JAMES Last SOTHORON		4. DATE OF DEATH Month April Day 19 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-28-1872 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY Medicine	11. BIRTHPLACE (State or foreign country) VIRGINIA
13. FATHER'S NAME Levin S. Sothoron, Sr.		14. MOTHER'S MAIDEN NAME Lillian Cantor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT NORWOOD SOTHORON, Charlotte Hall, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Cardiovascular Disease (c) 3 YRS.		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) operation 3-25-59: Acute Intestinal Obstruction - Recurrent			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 10, 1958 , to April 19, 1959 , that I last saw the deceased alive on April 19, 1959 , and that death occurred at 8:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Warren Jarboe M.D.		DATE SIGNED Apr 4-19-59	
PHYSICIAN'S NAME (Type) J. PARRIAN JARBOE, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-22-59	22c. NAME OF CEMETERY OR CREMATORY All Faith	22d. LOCATION (City, town, or county) (State) Charlotte Hall, Md.
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE APR 24 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1981

ST. MARYS

MARYLAND

CHARLES

LA 44314

20THURON

JAMES

LEVIN

Age 3

From County of Baltimore
Residence of Charles Levin

Specimen 3-25-21. Acute bacterial pneumonia heart

April 10 1981

8:10 PM

4-19-81

For 1 date

For 1 date

M.D.

JARROE

L. PARRAN

MD

From County of Baltimore

04272
Reg. Dist. No.

4282

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Waldorf</u>		c. LENGTH OF STAY IN lb <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>	
		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>Washington</u> Last <u>Washington</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u> <u>1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Montgomery</u>		14. MOTHER'S MAIDEN NAME <u>Maude</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mary Butler, Waldorf, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Apoplexy</u> <u>442X</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>C.V.D. Disease</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>April</u> , 19 <u>58</u> that I last saw the deceased alive on <u>Sept</u> , 19 <u>58</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>4-17-59</u>	
ACTUAL SIGNATURE <u>George W. Elder</u> M.D.		PHYSICIAN'S NAME (Type) <u>WALDORF MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-20-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Peters</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		ADDRESS <u>Waldorf, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4283

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La Plata			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude Middle L. Last Welch				4. DATE OF DEATH Month April Day 10 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11, 1894	
9. AGE (In years lost birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		11. BIRTHPLACE (State or foreign country) Charles County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Garrett Ching				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Hydrick B. Welch - Pomfret, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 190.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant Melanoma of Left Leg DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 Mos. 2 YRS.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 57 , to April 10 , 19 59 , that I last saw the deceased alive on April 10 , 19 59 , and that death occurred at 7:40 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. PARRAN JARBOE M.D.				ADDRESS (Street, city or town, state) La Plata, Md.		DATE SIGNED 4-11-59	
PHYSICIAN'S NAME (Type) J. PARRAN JARBOE M.D.				La Plata, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/1959		22c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		22d. LOCATION (City, town, or county) (State) Wayside, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC. * LA PLATA, MD.				24a. REC'D BY REGISTRAR DATE APR 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

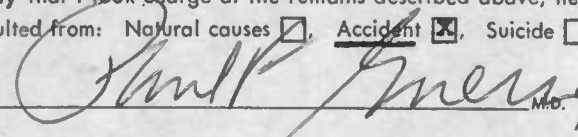
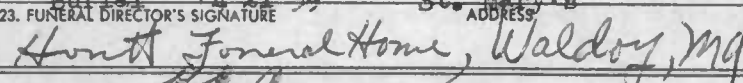
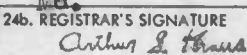
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04274

Reg. Dist. No.

4284

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital							d. STREET ADDRESS 		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First JAMES Middle WARREN Last WILKINSON				4. DATE OF DEATH Month April Day 18 Year 19 59									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 		9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labored				10b. KIND OF BUSINESS OR INDUSTRY tobacco barn		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME George F. Wilkinson						14. MOTHER'S MAIDEN NAME Mary Tippet							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 218-18-8871		17. INFORMANT Address Mrs. George F. Wilkinson, Waldorf, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning. Conditions, if any, which gave rise to immediate cause (b) Extensive Burns. (c), stating the underlying cause lost. DUE TO										INTERVAL BETWEEN ONSET AND DEATH 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration									
20c. TIME OF INJURY Hour XX p.m.		Month, Day, Year 4/18 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Waldorf		(County) Charles (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE 				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 4/20/59					
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4 21 59		22c. NAME OF CEMETERY OR CREMATORY St. Mary's				22d. LOCATION (City, town, or county) (State) Aquasco, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE 						24a. REC'D BY REGISTRAR DATE APR 22 '59		24b. REGISTRAR'S SIGNATURE 					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04275

4285

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u> c. LENGTH OF STAY IN 1b <u>Unk</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>LEE</u> Middle <u>L.</u> Last <u>WOOD</u>			4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-24-1888</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentry</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>George Wood</u>			14. MOTHER'S MAIDEN NAME <u>Cynthia Jane Parks</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>223-30-5237</u>		17. INFORMANT Address <u>Eugene Wood, Waldorf, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemiplegia athetoides</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-22</u> , 19 <u>57</u> , to <u>4-29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-29</u> , 19 <u>57</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D. <u>Brandywine, Maryland</u> PHYSICIAN'S NAME (Type) <u>Richard H. Dobson M.D.</u> <u>Brandywine, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The Hunt Funeral Home, Waldorf, Maryland</u>			24a. REC'D BY REGISTRAR DATE <u>MAY 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1958

Page One of

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar		13. Signature of medical examiner	
John Doe		Male		White		10/15/1920		New York City		New York City		10/25/1958		New York City		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
14. Name of informant		15. Relationship		16. Address		17. City		18. State		19. Zip		20. Date of completion		21. Registrar's name		22. Registrar's title		23. Registrar's address		24. Registrar's phone		25. Registrar's fax		26. Registrar's email	
Jane Doe		Wife		123 Main St		New York		NY		10001		10/26/1958		John Smith		Registrar		123 Main St		123-4567		123-4567		123-4567	